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ABSTRACT

This bibliography includes references from major articles, Index Medicus (1972- 1977), and Psychological Abstracts (1967-1977). The material is arranged under four major headings--health behavior, health education, health services utilization, and compliance with health regimes. It will be of interest to persons working in medical settings and those concerned with health maintenance and behavioral medicine. (JD)

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HEALTH BEHAVIOR, HEALTH EDUCATION, HEALTH SERVICE UTILIZATION AND COMPLIANCE WITH HEALTH REGIMES: AN ANNOTATED BIBLIOGRAPHY

J. R. Toledo
The Children's Heart Program of South Texas

Howard Hughes
North Texas State University

This bibliography includes references from major articles, index medicus (1972 to 1977), and psychological abstracts (1967 to 1977). The material has been arranged under four major headings--health behavior, health education, health services utilization, and compliance with health regimes. Health behavior refers to attitudes, beliefs, decisions, habits, actions, etc. that are related to health and illness. Such behavior may function on one hand to prevent or remediate illness, or on the other hand to initiate and/or maintain illness. As utilized here, health education is as defined by the Joint Committee on Health Education Terminology: "A process with intellectual, psychological, and social dimensions relating to activities which increase the abilities of people to make informed decisions affecting their personal, family, and community well being. This process based on scientific principles facilitates learning and behavior change in both health personnel and consumers, including children and youth . . ." The health services utilization section is concerned with the variables associated with the utilization and nonutilization of medical services. Finally, compliance with health regimes is focused on the incidence of and the techniques directed toward minimizing noncompliance with health regimes.

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The reference for each article is given first, then the annotation which consists of either the abstract or summary from the article, the abstract given in psychological abstracts, an abstract formulated by the senior author of the bibliography or an abstract formulated from representative quotations of the article. The source of each abstract is indicated at the end of the citation.

This bibliography may be of interest to persons working in medical settings and those concerned with health maintenance and behavioral medicine.

HEALTH BEHAVIOR, HEALTH EDUCATION, HEALTH SERVICE UTILIZATION AND COMPLIANCE WITH HEALTH REGIMES: AN ANNOTATED BIBLIOGRAPHY[1]

J. R. Toledo
The Children's Heart Program of South Texas

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Health Behavior

1. Abse, D. Wilfred et al. Personality and behavioral characteristics of lung cancer patients. Journal of Psychosomatic Research, 1974, 18, 101-113.

Conducted psychiatric interviews which focused upon some of the variables thought to be relevant to the distinction between cancer-prone personalities and other personalities. 59 patients, 31 later diagnosed as having lung cancer and 28 as having general cancer-free thoracic problems were interviewed in terms of these variables. Results show that patient groups could be successfully discriminated from one another only when behavior patterns were included in the analysis and were interpreted relative to the patient's age. Findings support the age hypothesis; i.e., that young cancer patients more frequently demonstrate and more clearly portray the characteristics attributed to lung cancer patients in general. (Psychological Abstracts)

2. Barnes, S. T. and Jenkins, C. D. Changing personal and social behavior: Experiences of health workers in a tribal society. Social Science and Medicine, 1972, 6, 1-15.

Overcoming the health problems of the modern world depends heavily on changing the behaviors of persons and groups. This paper presents the field experiences of a health educator and behavioral scientist as they worked to make a malaria eradication program acceptable to a tribal people. The approach to diagnosis of the problem of noncooperation and the initial steps and subsequent redirection of a remedial program are described. An interpretive summary brings into focus the anthropological, sociological, and psychological principles found to be important in this cross-cultural health promotion project. (Journal Abstract)

3. Bent, R., Putnam, D. G., Kiesler, D., and Nowicki, S. Correlates of successful and unsuccessful psychotherapy. Journal of Consulting and Clinical Psychology, 1976, 44, 149.

Determined whether a positive perception of the therapist is related to successful therapy outcome in 93 outpatients at a large mental health facility. Ss who were very satisfied with therapy, compared with those who were not very satisfied, described their therapists as warmer, more likeable, more active, and more involved and felt that therapy had a more noticeable effect on their behavior. (Psychological Abstracts)

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[1]This research is partially supported by Grant 90-C-907 from the Department of Health, Education, and Welfare, Office of Child Development.

4. Lozoff, B., Kamath, K. R., and Feldman, R. A. Infection and disease in South India families: Beliefs about childhood diarrhea. Human Organization, 1975, 34(4), 353-358.

During a microbiological study in Vellore, India, it was noted that children with diarrhea who became severely dehydrated were often not brought for international medical treatment. In an investigation of this problem 56 study families were interviewed to understand their beliefs about childhood diarrhea. Diarrhea was considered an individual disturbance of function that international medicine could appropriately treat. In contrast, dehydration was believed to indicate a state of pollution that required ritual purification. International medicine interprets dehydration as a complication of the physiologic disturbance of diarrhea; proper fluid management is the treatment for both diarrhea and dehydration. This analysis has identified the aspects of treatment considered essential by both international medicine and the families; therapeutic combinations were suggested that satisfy international medicine's requirement of rehydration and the families' insistence on purification. (Journal Abstract)

5. Britt, D. W. Social class and the sick role: Examining the issue of mutual influence. Journal of Health and Social Behavior, 1975, 16, 178-182.

Building on previous work, which suggested that illness symptoms might stabilize into more permanent responses (Scheff, 1966; Szasx, 1961; Dohrenwend and Dohrenwend, 1969), it is argued that there should be a reciprocal relationship between self-reported illness and social class. Data from a national panel study were used to test the hypothesis. Alternative explanations for the finding of reciprocal relationship were discussed and additional data were presented to document more finely the effect of movement into the sick role on subsequent wage income. (Journal Abstract)

6. Brown, J. S. and Ralwinson, M. Relinquishing the sick role following open-heart surgery. Journal of Health and Social Behavior, 1975, 16, 12-27.

One-hundred-and-fifty patients responded to a semantic differential instrument 1+ years after open-heart surgery. Patients perceived sick persons as less independent, less active, and not as good as people in general. The semantic distance between the concepts "most persons who are sick" and "msyelf after heart surgery" constituted the measure of the patient's tendency to relinquish the sick role. Explanation for variations in this tendency was sought in 19 physical, social, and personality variables belived to affect recovery. Upon regression analysis, five variables--depression, preoperative tendency to reject the sick role, duration of illness prior to surgery, age, and sex--emerged as significant predictors of tendency to relinquish the sick role following surgery. (Journal Abstract)

7. Bullough, B. Poverty, ethnic identity and preventive health care. Journal of Health and Social Behavior, 1972, 13, 347-382.

Low income mothers from three Los Angeles poverty areas, representing three ethnic groups, were questioned about the preventive health care they had obtained for themselves and their children. It was found that the more well-known barriers to the utilization of preventive services were reinforced by alienation, including feelings of powerlessness, hoplessness and social isolation. Family planning behavior was found to be the type of preventive care most influenced by alienation. (Journal Abstract)

8. Coburn, D. and Pope, C. R. Socioeconomic status and preventive health behavior. Journal of Health and Social Behavior, 1974, 15, 67-78.

Hypotheses explaining the link between SES and preventive health care were tested; and a preliminary predictive model for preventive health behaviour was developed. Variables relating to childhood socilization, social participation, work self-direction, work constraints, powerlessness-planfulness, and health knowledge were included as were several demographic variables. Separately, none of the explanatory variables greatly accounted for the influence of SES. Combined, however, they accounted for about half of the variance of SES. Together, education, age, income, and social participation (in that order) were found to provide the most parsimonious set for predicting general preventive health behaviour. (Journal Abstract)

9. Cohen, F. and Nazarus, S. Active coping processes, coping dispositions, and recovery from surgery. Psychosomatic Medicine, 1973, 35, 375-389.

Investigated the relationship between mode of coping with preoperative stress and recovery from surgery. 59 preoperative surgical patients were interviewed and classified into 3 groups based on the kind of coping behavior they exhibited: avoidance (n=13), vigilance (n=10), or both (n=36). Ss also completed the Sentence Completion Test, S. Epstein and W. D. Fenz's modified Repression-Sensitization scale, and the Schedule of Recent Experience. Results show that the vigilant group had the most complicated postoperative recovery, although only 2 recovery variables (days in hospital and minor complications) were significant ($p < .01$). Coping dispositions, anxiety, and life stress showed no clean relationships with recovery. (Psychological Abstracts).

10. Coustry-Degre, C. and Collard, L. Prognostic values of psychological factors in rehabilitation of patients after myocardial infarction. Acta Psychiatrica Belgica, 1974, 74, 381-388.

95 male patients, hospitalized for myocardial infarction (mean age=49 years) were interviewed within a few days of hospitalization and were given a battery of psychological tests 2-3 mo. later. After the 1st interview patients were classified into 3 types, confirmed by later testing. The impulsive type refused to accept that he was ill and exhibited hyperactive behavior. The adapted type accepted the illness and restructured his activities appropriately. The regressive type exaggerated his handicap and was overcome by fear and loss of motivation. The impulsive Ss returned to work earlier than both other groups but had the highest mortality rate. The regressive patients needed the longest time to return to work if they did at all. 36% of those who did not return to work had psychological rather than physical or technical reasons for doing so. The adaptive patients returned to work after a reasonable length of time had the lowest mortality rate. It is concluded that early detection of attitude toward illness and work can be used to indicate psychotherapy for the 2 nonadaptive types. (Psychological Abstracts)

11. Fabrega, H., Jr. Toward a model of illness behavior. Medical Care, 1973, 11, 470-484.

Behavioral processes associated with occurrences of disease offer a promise to the behavioral scientist interested in investigating recurring features of human behavior. Definitions of disease vary and ultimately rest on a set of historically bound symbols. These symbols, in turn, form the basis for the actions that are taken "vis-a-vis" disease. Nevertheless,

regardless of the framework that one might use as a basis for definition, "occurrences of disease" are universal. Members of all carefully studied contemporary human groups are prone to develop (and this has probably been the case for groups at all points in the evolutionary history of man) biological changes analogous to those that we term disease. Since occurrences of disease are universal, this means that human groups are more or less regularly confronted with decremental changes in human functioning which we assume are to some extent socially patterned. This in turn suggests that it may be possible to depict in an abstract way fundamental behavioral changes associated with an occurrence of disease. A first step in this direction would be the construction of an analytical model which accounts for the decisions that are made by a person during the time that he is ill. We could term this a model of illness behavior. The purpose of this paper is to put forth, in a preliminary fashion, an admittedly theoretical model of this decision-making process. The model to be discussed does not presume to describe the actual way in which persons make decisions during illness, but rather to offer an abstract account of how such decisions may be viewed or explained. In general, in the discussion that follows the term "disease" is used when reference is made to states that are biologically altered (i.e., chemical, physiological) and the term "illness" when speaking of the complex but socially defined state that forms the bases of decisions about medical treatment. (Journal Abstract)

12. Gochman, D. S. Some correlates of children's health beliefs and potential health behavior. Journal of Health and Social Behavior, 1971, 12, 148-154.

Predictions that perceived vulnerability to health problesm is (1) inversely related to potential health behavior in persons with high degrees of perceived internal control, (2) directly related to potential health behavior in persons with low perceived internal control, and (3) inversely related to perceived internal control in persons for whom health is salient, were all confirmed by a study of 108 children, aged 7 to 18, conducted at a summer camp. The results highlight the importance of an interplay of factors in determining health-related behavior, and are consistent with the health belief model. (Journal Abstract)

13. Goldstein, M. and Fenster, C. The role of the mental health practitioner in long-term medical treatment. Psychosomatics, 1973, 14, 153-155.

Discusses the often neglected aspect of the psychological side effects precipitated in chronically physically ill patients. Such patients have many restrictions on what they eat and drink; they tire rapidly and are unable to do some things they once took for granted. Their sexual potency diminishes. They may be in constant fear of death or be dependent upon dialysis by artificial kidney. Their plans for the future are threatened and they suffer from loss of occupation, financial strain, and marked changes in relationships with members of their family. The patient responds to these situations by increasing self-denial. The suicide rate for patients on chronic hemodialysis is 400 times greater than that for the normal population. Suicidal behavior is expressed by not adhering to the treatment regimen, e.g., ingestion of large amounts of fluids and foods forbidden by the dialysis regimen. (Psychological Abstracts)

14. Kasl, S. V. and Cobb, S. "Health behavior, illness behavior, and sick-role behavior." Archives Environmental Health, 1966, 12, 246-541.

In this review, we have gathered observations, made at the interface between medicine and social science, which deal with certain behaviors related to health and illness. These behaviors have been referred to as health behavior, illness behavior, and sick-role behavior. The conceptual model presented emphasized the interaction of the health-illness dimension with behavioral and indentity dimensions. This interaction is modified by a variety of characteristics of the person and his environment. It appears that most of the variance in regard to health behavior is accounted for by the interaction of perceived threat of disease and perceived value of preventive action. Since both of these perceptions seem to be influenced by education, occupation, and income, it is not surprising that social class often appears significant. With regard to symptoms and illness behavior, it is clear that the most important additional variable is psychological distress, especially depression. In future studies, anxiety, resentment, and low self-esteem also should receive serious attention. Finally, the sequence from disease to sick-role behavior is probably further influenced by the individual's motivation to get well and by the demands of the sick-role norms, which in turn are affected by certain personality and situational characteristics. Some directions for future research have been suggested--it is emphasized that both for studies of disease and studies of health-related behavior, it is important to keep the two separate in conception and in measurement. This area will probably form an increasing part of research and teaching in preventive and social medicine. (Journal Abstract)

15. Kegeles, S. S. Some motives for seeking preventive dental care. The Journal of the American Dental Association, 1963, 67, 90-98.

Interviews with 50 supervisory and 380 nonsupervisory employees of the Endicott-Johnson Corp. (which has a company-financed plan for dental care) established that among the motives prompting persons to seek preventive dental care are the following: a belief that one is susceptible to dental disease, a belief that dental problems are serious, a belief that dental treatment is beneficial, a belief in natural causality, an esthetic concern for one's teeth, a lack of anxiety about dental treatment, no fear of pain, and a positive appraisal of the dentist. (Journal Abstract)

16. Leventhal, H. Changing attitudes and habits to reduce risk factors in chronic disease. The American Journal of Cardiology, 1973, 31, 571-580.

Because individual attitude and behavioral patterns are strongly implicated in the causation and prevention of chronic disease, one must consider programs of behavioral change for adults, and preventive programs for children to reduce chronic disease risk factors. According to the concept of multiple causes, changing behavior requires that one understand the sequence of steps leading to change: exposure, understanding, change of attitude and action. Ways of actualizing these steps for behavioral change in adults are discussed for both mass media and interpersonal communication, and special attention is given to the doctor-patient relationship. The assumption that behavior is more easily controlled in children than adults underlies the emphasis on preventive approaches to health education. This assumption is analyzed with discussion of the lifetime stability of attitudes and habits, the appropriateness of early habits for later life, the comparative value of teaching specific habits versus general concept of health,

and the biological and social factors that create difficulties in communicating with children and produce motives counter to those required for sound health practices. It is concluded that prevention may be as difficult and complex as changing behavior in adults. Since all behavior is a product of ongoing processes, education for positive health practices is a lifelong task requiring equal attention to early and later education, and to environmental and individual factors. (Journal Abstract)

17. Mayou, R. Chest pain in the cardiac clinic. Journal of Psychosomatic Research, 1973, 17, 353-357.
Gave a medical and psychosocial examination to 50 new referrals to an outpatient clinic. The 29 noncardiac patients gave self-reports of improvement, yet almost 50% of them continued to report chest symptoms at follow up. It is concluded that there is little difference in psychosocial state or illness behavior between those with and without cardiac abnormality. (Psychological Abstracts).

18. McBroom, W. H. Illness, illness behavior and socioeconomic status. Journal of Health and Social Behavior, 1970, 11, 319-326.
A sample of disability-benefits applicants are used to explore the relationship between socioeconomic status and illness. Two possibilities are pursued: (1) that illness level varies by status and (2) that subjective responses about illness vary by status. No substantial linear association was obtained in either case. There was, however, a slight positive association between socioeconomic status and indicators of both self-perceived functional and self-perceived social limitations. Only the latter was relatively undisturbed when the actual level of limitations was controlled. These data do not reveal a pronounced influence of status on either illness levels or illness behavior. (Journal Abstract)

19. Pratt, L. Child rearing methods and children's health behavior. Journal of Health and Social Behavior, 1973, 14, 61-69.
A developmental pattern of child rearing was found to be associated with better health care practices by children than a disciplinary pattern of child rearing. The developmental methods included substantial use of reasons and information, rewards, and granting of autonomy. Based on these findings and a review of previous research, the higher level of health practices of children reared by developmental than of those reared by disciplinary methods is interpreted as an expression of the differential effectiveness of these contrasting child rearing approaches in developing the child's resources and capacities for coping and taking care of himself. (Journal Abstract)

20. Pritchard, M. Dimensions of illness behaviour in long term hemodialysis. Journal of Psychosomatic Research, 1974, 18, 351-356.
The responses of 14 patients undergoing hemodialysis to a 22-item questionnaire were factor analyzed. (Psychological Abstracts)

21. Rahe, R. H., Biersner, R. J., Ryman, D. H., and Arthur, R. J. Psychosocial predictors of illness behavior and failure in stressful training. Journal of Health and Social Behavior, 1972, 13, 393-397.
A unit score developed from the Schedule of Recent Experience (SRE) and the total "yes" score of the Cornell Medical Index (CMI) Health-Questionnaire were found to be valid predictors of dispensary visits made during stressful Underwater Demolition Team (UDT) training. When the SRE and CMI scores were taken together, their multiple correlation with subjects'

dispensary visits was found to be significantly higher than the correlations of either one alone. Subjects' SRE scores showed highest correlation with those men who eventually dropped from training because of medical problems ("approved" illness behavior). Subjects' CMI scores were seen to have an unique correlation with those men who dropped from training voluntarily--often with minor illness symptoms ("unapproved" illness behavior). In addition, subjects' CMI scores showed a consistent significant correlation with failure to complete UDT training. (Journal Abstract)

23. Suchman, E. A. Stages of illness and medical care. Journal of Health and Social Behavior, 1965, 6, 114-128.

The illness experience is described and analyzed according to the following five stages demarcating critical transition and decision-making points in medical care and behavior; (1) symptom-experience; (2) assumption of the sick role; (3) medical care contact; (4) dependent-patient role; (5) recovery or rehabilitation. Each state is found to present new problems and to require different kinds of decisions and medical actions. The data support the general proposition that the behavior of the sick individual is dictated by both social and medical considerations. In most cases, the pathways and routines established by the formal medical system appear to function quite smoothly. (Journal Abstract).

24. Twaddle, A. C. Health decisions and sick role variations: an exploration. Journal of Health and Social Behavior, 1969, 10, 105-115.

Case interviews are used to explore variations in illness behavior and Parsons' sick role formulation. A decision-making model, focusing on the influence of status and role definers (significant others), produced findings relative to the nature of being "well," assignment of a "sick status," and illness behavior. While Parsons' formulation describes modal categories when each component is taken alone, his total configuration describes only a minority of responses. Seven sick role configurations are identified. In addition to interpersonal influence, the nature of "well roles" and the nature and severity of the illness are important variables for the study of illness behavior. (Journal Abstract)

25. Ubell, E. Health behavior change: a political model. Preventive Medicine, 1972, I, 209-221.

It appears that the lifestyle of populations has as much to do with health as the medical care delivery systems. Diet, exercise, smoking, drugs, accidents, and cleanliness--all related to health--are functions of styles of behavior. Today, the health worker must be concerned with behavior change leading to health as he is with the delivery of disease care.

In the past, such programs have been called health education, but it is clear that the old forms of health education which emphasized information are not sufficient to influence behavior in a wide scale. Those who would change behavior must take into account a wide range of social and psychological differences. A single message will not change behavior in the same way for different parts of the population.

The literature of behavior change suggests strongly that "psychological" rather than informational approaches can produce specific behavior responses. It is also important to make sure that the modality for behavior change is easily available and that the surrounding social milieu is appropriate for that change.

This article suggests as a model for the health worker the political campaign in which precampaign attitude surveys are made and careful analyses

of communications allocate resources to the optimum. The political campaign dwells on behavior change rather than "education" as such and the health worker can learn a lot not only from the techniques used by modern office seekers but from practical efforts.

Finally, small percentages of changes of behavior often provide large payoffs in lives saved and disease prevented. An example is given on the recruitment of heavy drinkers which if carried out could prevent more alcoholism than all the hospitals in America can now treat. Certain ethical issues are also treated. (Journal Abstract)

Health Education

1. Black, L. A. and Brown, D. D. Public information and heart attack. The Ohio State Medical Journal, 1973, 69, 369-374.

A county with a stable population of 30,000 was the setting for an intense one-year program designed to reduce patient-decision time by educating the public to recognize and act upon the symptoms of an impending myocardial infarction. Personal encounters between health professionals and the general population was the main vehicle used in an attempt to effect both cognitive and behavioral change. A pre-and post-project survey indicated an increased public awareness of the symptoms of an impending heart attack. There was also an increase in the number of possible myocardial infarctions admitted or seen in the coronary care unit, but we felt it fell far short of a panic reaction. In the 12-month period following the project's start, there was a significant reduction in delay time between the onset of myocardial infarction and entrance into the coronary care unit. (Journal Abstract)

2. Collen, F. and Soghikian, K. A health education library for patients. Health Services Reports, 1974, 89, 236-243.

Describes the operation, staffing, and use of a library for medical patients. The library is designed to help patients understand and manage their problems and as an educational resource for the community. (Psychological Abstracts)

3. Galli, N. Foundation of health education. The Journal of School Health, 1976, 46, 158-165.

Health education is "the process of providing or utilizing experiences for favorably influencing understanding, attitudes, and practices relating to individual, family, and community health. As an applied science it draws its content from a variety of sources. The paradigm which depicts the foundations of health education can be visualized as five vertical pillars consisting of sociocultural, educational, psychobehavioral, legal, and scientific foundations supporting the work of the health educator. While the components within each pillar may be altered with new developments and advances over time, the model is broad enough in scope to incorporate the changes without altering its purpose. The foundations of health viewed in this light can easily display the depth of the health education profession and will serve to orient the novice and future health educators of the underpinnings of their profession. This framework could easily be adapted for study on the college level and should serve as an orientation to those students planning to major in health. (Journal Abstract)

4. Gillum R. F. Patient education. Journal of the National Medical Association, 1974, 66, 156-159.

Patient education must be part of the "plan" for each inpatient and part of the prescription for each outpatient if medical care is to attain its goal of improving the health status of each patient. Individual instruction is the mainstay of patient education attempts and can be greatly increased in effectiveness by the elimination of the several barriers to communication listed. Ancillary methods such as group educational sessions and audio-visual techniques can also contribute to the effectiveness of patient education. (Journal Abstract)

5. Health education project general advisory committee. Making health education work. American Journal of Public Health, 1975, 65, 1-49.

The information assembled here represents the first effort to present an overall picture of how health education principles were applied in the past decade to health programs serving low-income and minority groups. It includes suggestions for strengthening educational efforts, and it points up deficiencies which must be overcome if education is to realize its potential value in the health system. (Representative Abstract)

6. Hall, G. E., Loucks, S. F., Rutherford, W. L., and Newlove, B. W. Levels of use of the innovation: a framework for analyzing innovation adoption. Journal of Teacher Education, 1975, 26, 52-56.

Change and the tendency to embrace or to resist it seem always to have been a part of the human condition. Change leads to consternation for some, indignation for others, shock for still others, and hope for a few. Because of this inherent potential for trauma, defining concepts and developing measurement procedures for assessing what is actually accomplished by change is difficult and challenging work. All too frequently the affective dimension of change draws a veil that obscures what the innovation users are actually doing. In this paper, we would like to describe a hypothesized dimension of innovation adoption that we have defined and are measuring, which attempts to assess what the individual innovation user actually does in using an innovation. The dimension seems to have power for practictioners, researchers, and theoreticians alike--particularly in education, where innovation adoption is so widespread, and where the public interest in change is so intense.

Eight discrete levels of use of an innovation that an individual may demonstrate are proposed. These levels range from lack of knowing that the innovation exists to an active, sophisticated and highly effective use of it and, further, to active searching for a superseding innovation. It is further hypothesized that growth in quality of use of an innovation (movement toward higher levels) by most individuals is developmental. Normally, individuals do not use an innovation for the first or even the second time as effectively and efficiently as they do after four or five cycles of use. (Representative Abstract).

7. Iverson, D. C. and Hosokawa, M. C. Health education research: accomplishment or exercise. The Journal of School Health, 1976, 45, 154-156.

Comments on the abundance of research classified on "baseline" but few efforts to analyze health education approaches to affect documented problems. Encourages the training of health educators not only academically prepared but capable of conducting meaningful research and motivated to apply gained knowledge. Cites six major areas in need of further research: (1) identify health problems based on behavior and make them the basic content of health education programs; (2) make cost analysis studies to determine the long-term effectiveness of health education programs in reducing personal health care costs for specific types of health problems; (3) give priority to research into human motivation as it relates to influencing the quality of health habits and practices; (4) test various health education approaches to determine the ones bringing about the best results in patient improvement and reduction of health services; (5) with periodic surveys, determine the health education needs and interests among school children in developing health education programs; (6) that business industry and labor encourage and support basic research to determine the effectiveness of health education

in increasing the quality of life, reducing absenteeism from work, and increasing productivity. (Author's Abstract)

8. Johnson, E. and Leventhal, H. Effects of accurate expectations and behavioral instructions on reactions during a noxious medical examination. Journal of Personality and Social Psychology, 1974, 29, 710-718.

Conducted a field experiment in a threatening situation to test the relationship between 2 types of reactions: emotional and danger-control-oriented. Ss were 48 hospitalized medical patients who received an endoscopic examination. 2 types of preparatory messages were constructed, 1 to reduce emotional reactions and the other to increase performance of danger-control behaviors. 4 groups were formed by presenting the messages singly and in combination and by presenting no experimental message to a comparison group. The data indicate a greater degree of interdependence between the fear- and danger-controlling processes than expected. The behavioral instruction message significantly affected the indicators of control of danger only when combined with the sensory description message. Sensory description alone and in combination with behavioral instruction reduced selected indicators of emotional reaction. 2 situational factors--the highly threatening nature of the endoscopic examination and competition between emotional and controlling behaviors for the same response system at the same time--were identified as possible causes of observed interdependency between the 2 types of reactions. (Psychological Abstracts)

9. Jones, W. T. and Grahame, H. Research in health education. British Medical Bulletin, 1974, 30, 276-281.

Mentions some of the shortcomings of health education: the failure of the epidemiologists to define the behavioral causes of the major diseases of unhealthy behavior; doubts about the contribution of behavioral sciences, the imprecisions of communication processes, and the essentially empirical and pragmatic bases of education. It points out the need for more information and integration of vital statistics; human physical financial resources; voluntary and statutory community work; community attitudes toward health, health knowledge, and health behavior patterns. It suggests the organization and long-term planning by health information centers; the coordination and evaluation of available knowledge; the use of mass media; the role of the government in program implementation; the potential of nonmedical personnel and health education in schools. It concludes with some comments on six of the most common public health problems--smoking, nutrition, exercise, coronary heart disease, accidents, and cancer. (Author's Abstract)

10. Kegeles, S. S. A field experimental attempt to change beliefs and behavior of women in an urban ghetto. Journal of Health and Social Behavior, 1969, 10, 115-124.

Using standard personal messages within an urban ghetto, an attempt was made to (1) change women's beliefs in vulnerability to cervical cancer and in the effectiveness of cytology, and (2) persuade them to visit a cytological clinic. More women with higher post-belief scores made visits than their counterparts. The experimental message was more successful than the control in eliciting clinic visits. Though the experimental message did not change beliefs more than the control message, more experimental subjects high in post-beliefs came to the clinic than (1) experimental or control subjects low in post-beliefs, or (2) control subjects high in post-beliefs. (Journal Abstract)

11. Langer, E. J., Janis, I. L., and Wolfer, J. A. Reduction of psychological stress in surgical patients. Journal of Experimental Social Psychology, 1975, 11, 155-165.

Assessed the effectiveness of 2 stress-reducing strategies in 60 adult surgical patients. The 1st strategy consisted of a coping device which entailed the cognitive reappraisal of anxiety-provoking events, calming self-talk, and cognitive control through selective attention. The 2nd strategy consisted of supplying information about the threatening event along with reassurances for the purpose of producing emotional inoculation. Ss were exposed to either the coping device, the preparatory information, both strategies, or neither. The prediction that the coping device would effectively reduce both pre and postoperative stress was confirmed. An analysis of nurses' ratings of preoperative stress showed a significant main effect for the coping device. There was also a significant main effect for the coping device on postoperative measures (number of pain relievers requested and proportion of Ss requesting sedatives). The preparatory information, however, did not produce any significant effects on these postoperative measures. (Psychological Abstracts)

12. Lupton, E. Differential patient response to instruction, counseling, and dental treatment. Paper presented at a national seminar on adult education research, Chicago, February, 1968.

Research (1) analyzed specific outcomes of counseling, instruction, and dental therapy; and (2) determined the relative effectiveness of patient education for relief of temporomandibular joint (TMJ) dysfunction. Sixty adult patients attending the University of Illinois TMJ Research Center were randomly assigned to one of three programs--Dentistry, Dentistry and Instruction, or Dentistry and Counseling. In the pretest stage, a dental examination determined the severity of the dysfunction; and interviews and testing determined motivation for counseling, educational level, knowledge of the dysfunction, and self-concept. Results indicated that (1) dental treatment combined with instruction or counseling is superior to dental treatment, (2) dental treatment and instruction are superior to dental treatment alone or combined with counseling, and (3) the combination of counseling and dental treatment is superior to either dentistry alone or combined with instruction in decreasing a patient's negative feelings about himself. An abstract of a doctoral thesis, this paper was presented at a national seminar on adult education research (Chicago, February 11-13, 1968). (Psychological Abstract)

13. Lynch, L. R. The conceptual approach to teaching health education. The Journal of School Health, 1973, 43, 130-132.

Numerous articles which acclaimed the worth of the conceptual approach to teaching health education, grades K-12, have appeared in the literature. Some articles describe this curriculum and the possibilities inherent in its use, while others mention the limitations as well as the assets of this approach. This report differs from earlier reports in that it presents a brief summary of how a group of cadet teachers perceive this approach and shows the results of their efforts to use it during their teaching internship experience with junior high school students. The conceptual approach seems to help students arrive at their own understanding (self concepts) through an active thinking process resulting from their study experiences, if they are being taught "what they want to know." Given the opportunity to explore their prime interests, they become motivated and more receptive to other varied

ideas that might be directly or remotely related to their chief interest. (Representative Abstract)

14. Melamed, B. G. and Siegel, J. Reduction of anxiety in children facing hospitalization and surgery by use of filmed modeling. Journal of Consulting and Clinical Psychology, 1975, 43, 511-521.

Sixty 4-12 year old children about to undergo elective surgery for hernias, tonsillectomies, or urinary-genital tract difficulties were shown on hospital admission either a relevant peer modeling film of a child being hospitalized and receiving surgery or an unrelated control film. Both groups received extensive preparation by the hospital staff. Stated measures of anxiety, including the Hospital Fears Rating Scale, the Observer Rating Scale of Anxiety, and Palmar Sweat Index, revealed a significant reduction of preoperative (night before) and postoperative (3-4 weeks postsurgery examination) fear arousal in the experimental as compared to the control film group. The parents reported a significant posthospital increment in the frequency of behavior problems in the children who had not seen the modeling film. Trait measures of anxiety (e.g., Children's Manifest Anxiety Scale and the Human Figure Drawing Test) did not reflect the group differences due to the nospital experience. (Psychological Abstracts)

15. Osman, J. D. A rationale for using value clarification in health education. The Journal of School Health, 1973, 43, 621-623.

Lists specific advantages of the value clarification approach which health education may want to examine more carefully for its potential value in closing the gap between information and behavior change.

The listed advantages of value clarification for the student are:

1. Lifts facts and concepts to a personal level.
2. Humanizes education by encouraging students to examine their feelings.
3. Provides students with a consistent, reliable reference point (the process of valuing).
4. Many of the strategies encourage reflective thinking and/or introspection on the part of the student.
5. Value clarification minimizes teacher power and authority.
6. Assists students in answering:
   a. Who am I?
   b. What do I stand for?
   c. Where am I going?
7. Helps students move toward greater consistency between thoughts and speech, speech and actions.
8. Individualizes instruction by providing each student the opportunity to get in touch with what he believes is right for his own life at that point in time.
9. Minimizes value inculcation by the teacher.

The teacher advantages of value clarification are:

1. Removes the "blahs" and boredom from teaching.
2. Provides educators with specific teaching strategies.
3. The 100-plus teaching strategies are adaptable and flexible to different grade levels and learning situations.
4. Creates a nondirective, nonthreatening, nonjudgmental classroom atmosphere.
5. Teacher no longer has to defend or justify traditional value positions held by society.
6. The seven-step process of valuing provides educators with a framework for course design. (Representative Abstract)

16. Osman, J. D. The use of selected value-clarifying strategies in health education. The Journal of School Health, 1974, 44, 21-25.

The purpose of this study was to explore the feasibility of using selected value-clarifying strategies in a health education course for future teachers. The study was further designed to develop, modify, describe, and evaluate these selected strategies. Subpurposes included identifying the potential advantages and possible limitations of value clarification for health education; assessing student success in the valuing process; providing opportunities for students to learn the process of valuing; and assisting the student in reducing the gap between speech and actions.

It was theorized that if a consistent application of value-clarifying strategies based on the seven criteria of valuing could help reduce the gap between what people know and what people do, it would seem that value clarification might be an effective learning-teaching process to use in health education.

College juniors and seniors preparing to be secondary teachers who were enrolled in the investigation's sections of Health Education 301 at the Ohio State University during the spring quarter 1971 comprised the study population.

Students were instructed in the usual course content but with a focus on the seven levels of valuing: (1) choosing freely; (2) choosing from alternatives; (3) choosing after thoughtful consideration of the consequences of each alternative; (4) prizing, being happy with the choice; (5) publicly affirming the choice; (6) acting on the choice; and (7) acting repeatedly as a pattern of life. Twenty value-clarifying strategies were modified, altered, or designed to assist students in two or more levels of valuing.

In summary, the stated results of this investigation combined with the feedback of students throughout the quarter, interpreted and analyzed in relation to the teaching experiences of this investigator, lead to the conclusion that the use of selected value-clarifying strategies in a health education course for future teachers is not only feasible but also personally satisfying and professionally edifying. (Representative Abstract)

17. Patterson, E. and Rowland, G. Developmental Nursing. Journal of Continuing Education in Nursing, 1971, 2, 14-22.

The new developmental role of the nurse, as it is emerging, charges the nurse with the responsibility of educating the people under her care so that they will function more efficiently in their environments. (Psychological Abstracts)

18. Quadrio, A., Castagna, P. C., and Strambio de Castilla, N. Remarks about an experience of organization of a playing room in a pediatric hospital department. Acta Medica Auxologica, 1974, 6, 117-129.

Examined the effect of guided play and the desirability of having a playroom in a pediatric hospital. Ss were 50 experimental Ss and 50 controls, 2-6 years old. Results suggest that those receiving guided play were less anxious, slept better, and showed fewer regressive behaviors than the control group. The importance of having therapeutically trained staff to guide the play of children in pediatric hospitals is emphasized. (Psychological abstracts.

19. Richards, N. D. Methods and effectiveness of health education: the past, present, and future of social scientific involvement. Social Science and Medicine, 1975, 9, 141-156.

The aims of this paper are (a) to focus attention upon health education as a key subject area lying fairly and squarely at the crossroads of social

science and medicine and (b) to provide a selective review of social science concepts relevant to the practice and research of health education. Within the context of this paper, health education is taken to be a legitimate and dynamic area of concern for both social scientists and health professionals in their efforts not only to understand but also to bring about favorable changes in health behavior and response to available health services. In this respect, health education is viewed as an applied field for the translation of social and behavioral scientific study and research into action programs which are designed to seek improvements both in knowledge and practice relating to health. (Representative Abstract)

20. Robertson, Leon S. Behavioral research and strategies in public health: a demur. Social Sciences and Medicine, 1975, 9, 165-170.

Amelioration of public health problems historically has followed the discovery of manipulable necessary conditions for the problems. Concepts and methods used in much behavioral research on current public health problems indicate a lack of awareness of this principle. Ameliorative strategies that require action on the part of each individual to be protected, called active strategies, are less effective than strategies that do not require changes in the behavior of everyone protected, called passive strategies. By often focusing on individual behavior, social scientists have tended to neglect organizational structures and processes that are major factors in the adoption of ameliorative passive strategies. (Journal Abstract)

21. Samora, J., Saunders, L., and Larson, R. G. Medical vocabulary knowledge among hospital patients. Journal of Health and Human Behavior, 1961, 2, 40-92.

Unfortunately, there are many barriers to ideal communication between medical practitioner and patient: the physical inability of the patient to hear what is said to him; his psychological unwillingness to receive unpleasant information or to impart information about private matters; anxieties and inhibitions stemming from perceived status differences or from uncertainties about the clinical situation; and his inability to remember clearly past experiences or to formulate and relate what he does remember. Still other sources of communication difficulty are to be found in differences in what patients and physicians know about disease and normal and abnormal physiology; in factors associated with social class or ethnic group membership; in the differing role expectations patients and physicians may have of themselves and each other; and in differences in ability to comprehend terms commonly used in medical discourse. This paper is primarily concerned with one of these factors. It reports findings that bear upon the ability of inpatients in a public general hospital to understand selected medical terms frequently used in that hospital. It also attempts to isolate some of the factors associated with observed differences in levels of understanding. A vocabulary schedule was constructed and a random sample of fifty words was administered to 125 patients randomly selected from the hospital wards. No respondent gave an adequate meaning to all fifty words, and no single word was adequately defined by all respondents. The range of individual responses judged adequate for communication was from 11 to 47 words with a mean of 28.9 and a median of 29 words. (Representative Abstract)

22. Schoenrich, E. H. The potential of health education in health services delivery. Health Services Reports, 1974, 89, 3-7.

Stresses the contribution of disciplines such as psychology, sociology, behavioral science, and cultural anthropology in the area of patient education.

It takes a systematic effort by a number of professionals and consists of a number of orderly steps from assessing the patient's knowledge, insuring the patient's comprehension and acceptance, integrating the information into his attitudes and producing beneficial behavioral changes.

Mentions the importance of health education in preventive medicine, its impact in the control of increasing problems of chronic illness and the aged, increasing costs of health services, and problems of health manpower.

It concludes by mentioning three major constraints in the development of patient education programs: the lack of organization by a national center, the lack of manpower trained in health education, and the lack of funding for health education programs. (Author's Abstract)

23. Sikic, I., Walker, D., and Peterson, D. R. An evaluation of a program for the treatment of alcoholism in Croatia. International Journal of Social Psychiatry, 1972, 18, 171-182.

Describes in detail the course of treatment followed at the Institute for the Study and Control of Alcoholism, Zagreb, Yugoslavia. The program emphasizes education, family involvement, and continued contact with outpatients. The daily schedule of the patient includes drugy therapy, group therapy, education, occupational therapy, recreation, music therapy, and family therapy. Summary figures present patient profiles, rates of improvement, and describe the local prevalence of alcoholism. Continued abstinence is highly related to the patient's joining a Club of Treated Alcoholics, his family's participation in the program, and his ability to secure and maintain employment. (Psychological Abstracts)

24. Sly, R. M. Evaluation of a sound-slide program for patient education. Annals of Allergy, 1975, 34, 94-97.

The understanding and cooperation of the patient and/or family is usually essential for optimal medical therapy. This is especially important in the treatment of allergy. Some of the information and instructions conveyed by the allergist to the patient can be quite similar for most patients with asthma. Such information is often transmitted in printed form, but such forms can be lost, forgotten, disregarded, or incompletely understood. Detailed instructions are best given through personal interview; but lengthy dialogues or monologues may fatigue the patient or parent with consequent impairment of retention, and complete reliance on this approach is time consuming for both patient and physician. As a result, patients can often receive inadequate counseling. Some combination of various methods of presenting essential information seems most desirable.

Programs of audiovisual instruction with lantern slides and audio tapes have been reported useful in the education of medical, dental, and veterinary students, but no evaluation of the usefulness of such programs in patient education has been published heretofore. This study was undertaken to assess the value of a synchronized sound-slide program in patient education.

Sixteen asthmatic children and their mothers were exposed to an educational experience by electronic means, and the educational experience was provided by the physician for another sixteen. The programmed instruction was supplemented in both groups with further instruction concerning other aspects of treatment, presented directly by a physician as well as printed material. There was no significant difference in the effect of the method of instruction as determined by administered questionnaire, and no significant difference in compliance was determined by home visits. (Representative Abstract)

25. Somers, A. R. Community health education: a challenge to hospital and medical staffs. The Journal of the Medical Society of New Jersey, 1973, 70, 943-948.

Describes favorable results of the health education activities of a hospital in areas such as diabetes, venereal diseases, pregnancy, etc.

Includes examples of other successful community health education projects such as training courses for babysitters, alcoholism clinic for drunk drivers, and public information on the signs of heart attacks.

Points out that in spite of increased technology and failure to control health problems that technically can be controlled, the missing ingredient appears to be the active understanding and cooperation of the consumer-patient.

Quotes a study which suggests that health status, based on measures of selected conditions, does not differ by provider organization. Another study directed to identify barriers to health care reported statements such as:

"Consumers lack understanding of preventive measures."

"Consumers lack understanding of when services are needed."

"Communication between providers and consumers is inadequate."

"Consumers lack understanding of how to enter the health-care system."

"Consumers and providers view service as a reactive rather than a preventive function."

"The 'medical mystique' causes consumers and trustees to hesitate to take issue with the physician."

Concludes with comments on cost effectiveness illustrated by the example of a physician utilizing health education to serve a large number of patients. (Author's Abstract)

26. Tosteson, D. C. The right to know: public education for health. Journal of Medical Education, 1975, 50, 117-123.

This paper points out the need to sensitize and train health providers in the area of health education, the patient's right to receive information necessary to make informed decisions, and the need to individualize health education. It elaborates on some of the important issues on health education such as the role of ignorance in public health, the fact that knowledge does not assure healthier behavior, the need to get active patient participation in the maintenance of his own health, the influence of health education in the design of public policies, and the role of health providers in health education. (Author's Abstracts)

27. Vernon, D. T. and Bigelow, D. A. Effect of information about a potentially stressful situation on responses to stress impact. Journal of Personality and Social Psychology, 1974, 29, 50-59.

Tested I. L. Janis's explanation for the ameliorative effect of information on stress impact in a study of 80 hernia-repair patients. It was proposed that Ss receiving accurate information about impending surgery would experience heightened anticipatory fear, develop specific problem-oriented ideas about the operation, profess greater confidence in the medical staff, and consequently manifest less postoperative depression and hostility. Exp. I assessed the effects of detailed, accurate information on preoperative attitudes and affective states; Exp. II, the effects on postoperative affect and behavior. Results support some aspects of Janis's theory (i.e., the development of problem-oriented ideas, specific reassurances, and the reduction of hostility as a result of increased informedness). However, there was no evidence that these presumed consequences of preparation were in any way related to "anticipatory fear" or "the work of worrying" as Janis proposed. (Psychological Abstracts)

28. Wolfer, J. A. and Visintainer, M. A. Pediatric surgical patients' and parents' stress responses and adjustment as a function of psychologic preparation and stress-point care. Nursing Research, 1975, 24, 244-255.

Tested the hypotheses (a) that children who receive systematic psychologic preparation and continued supportive care, in contrast to those who do not, would show less upset behavior and more cooperation in the hospital and fewer posthospital adjustment problems and (b) that their parents would be less anxious and more satisfied with information and care received. 50 male and 30 female 3-14 yr. olds scheduled for minor surgery, and their parents, were randomly assigned to experimental and control conditions. The experimental intervention consisted of accurate information about sequences of events, sensory experiences, role expectations and appropriate responses, previews of procedures through play techniques, and supportive care given at critical points pre and postoperatively. Significant differences between experimental and control children and parents on ratings of upset behavior, cooperation with procedures, pulse before and after painful procedures, resistance to induction, time to first voiding, posthospital adjustment, and parental anxiety and satisfaction with information and care consistently supported the hypotheses. Results are analyzed in relation to the age and sex of the children and whether parents roomed with the children. (Psychological Abstracts)

29. Yarrow, A. The use of the mass media in health education. Community Health, 1973, 4, 244-248.

The background to the recent adoption on a larger scale and in a more varied field of the use of the mass media in health education is presented. The variation of aims is discussed and examples of different kinds of campaigns carried out by the Scottish Health Education Unit with different aims in view is catalogued. Our experience of the hurdles to be overcome is presented and suggestions made as to how attempts have been made to overcome these. The need for evaluation is stressed and some of the difficulties met in attempting evaluation are outlined. Finally, there is a warning concerning the temporary effect of campaigns and discussion of a further health education tool, now the subject of experimental work, which may assist in overcoming this difficulty. (Journal Abstract)

Health Services Utilization

1. Anderson, J. G. Demographic factors affecting health services utilization: a causal model. Medical Care, 1973, 11, 104-120.

A causal model has been developed relating patient-days per thousand population and its components, hospital admission rates and average length of stay, to demographic characteristics of New Mexico counties. Data from the U. S. Census 1960, the New Mexico State Department of Business Research, and the annual Guide Issue of "Hospitals," the Journal of the American Hospital Association, have been used to estimate parameters of this model. Analysis of the model suggests that the supply of hospital beds is a major determinant of utilization in an area. In those areas where alternative health services are lacking or inadequate, an increase in the supply of beds significantly alters both the admission rate and the average length of stay. Socioeconomic factors such as income level, educational level, and ethnic composition have surprisingly little effect on the use of hospital facilities in New Mexico, a fact that probably reflects the major changes that have occurred in financing hospitalization during the past several decades. At the same time, hospital utilization rates appear to be highly sensitive to even small changes in the age structure of the population. Urbanization also affects the use of short-term general hospitals primarily due to the increased availability of hospital services to urban populations. The findings suggest that inpatient hospital care is substituted for ambulatory care normally provided by physicians in areas where the physician-to-population ratio is low. In general, the findings of this study clearly demonstrate the value of causal models in ascertaining the effects of demographic factors on the use of health care services and in planning for future demands on the system. (Journal Abstract)

2. Anderson, J. G. Health services utilization: framework and review. Health Services Research, 1973, 8, 184-199.

Five different approaches that have been used to study the utilization of health services are reviewed: the sociocultural, sociodemographic, social-psychological, organizational, and social systems. Studies characterizing each approach are described and the limitations of each perspective are outlined. It is suggested that social system models that explicate causal structures and that incorporate features of all the other approaches may provide important new insights into utilization behavior. (Journal Abstract)

3. Baggish, D. A. and Kimball, C. P. The problem of transportation to medical facilities on an indian reservation. Medical Care, 1973, 11, 501-508.

Inadequate means of transporting patients to central medical facilities remains a large impediment to the delivery of medical care on the Navajo Indian Reservation. The extent of the problem was studied at the Tuba City PHS Hospital by direct interviews with outpatients. No organized system of public transportation was found. Only 30 percent of the families questioned owned vehicles. Most others came to the hospital by walking, hitchhiking, or paying large fees to neighbors. Also isolation, great distances, poor roads, and long transit times were encountered. The resultant immobility of the Navajo is discussed as a deterrent to adequate health care. (Journal Abstract)

4. Bambino, C. F. Dimensions of acceptance; client perceptions of public health nurse home visit service. Dissertation Abstracts International, 1969, 161; Ph.D. Thesis. Available from: University Microfilms, 300 N. Zeeb Rd., Ann Arbor, Michigan, 48106 (Order No. 69-18, 879).

An exploratory study focused on how, when, and under what conditions clients with long-term illness and their families view the Public Health Nurse Home Visit Service (PHNHVS) as assisting them in family health care. Data were obtained from home interviews and nurse records of 68 families served by 13 nurses in one San Francisco Bay Area locality. Situational influences were the home setting, medical regime, source of control, (public or private), and the nurse's behavior. Acceptance of the PHNHVS by clients was based on the source of medical care. The service was not perceived as one which clients would voluntarily request or use for help in family health care. It was seen as helpful for learning technical skills or clarifying medical conflict when the condition of long-term illness was acute or newly diagnosed. Over a period of time, nurse visits were continued mainly on the basis of nurse behavior. However, the service was seen as one of public control and community protection. Implications were derived for adult education and for public health nurse service and practice. (Psychological Abstracts)

5. Ben-Sira, Z. The function of the professional's affective behavior in client satisfaction: a revised approach to social interaction theory. Journal of Health and Social Behavior, 1976, 17, 3-11.

Proposes a revised model of social interaction concerned with the professional-client relationship. Contrary to the traditional interaction models, in such a type of interaction the client may be unable to judge the extent to which the content of the professional response furthers the achievement of his or her goals; thus the mode of the response rather than its content may serve as a major factor influencing the stability of the interaction. Empirical investigation was carried out with regard to the case of the general practitioner (GP) in Israel. Data from interviews with 1,892 adults support the proposal, revealing that the GP's "Affective" behavior is a decisive factor in the crystalization of the layman's satisfaction with the GP's response. (Psychological Abstracts)

6. Bice, T. W. and White, K. L. Factors related to the use of health services: an international comparative study. Medical Care, 1969, 7, 124-133.

Data about the use of physicians' services, collected by means of surveys of the populations of Chester, England; Chittenden County, Vermont; and Smederevo, Yugoslavia, were analyzed by multivariate techniques. The results indicate that levels of perceived morbidity account for the greatest amounts of variance of utilization within each area, and that the occupational level of household heads and persons' tendencies to use services are also related to utilization. In addition to these factors, the variable measuring the availability of medical care contributed to explaining differences in the use of physicians' services in Smederevo. (Journal Abstract)

7. Billings, J. E. and Paul, M. F. Commercial airlines industry: some lessons for health services planners. Medical Care, 1973, 11, 145-155.

Policy actions taken in one market setting may be useful experience for planners in another. This, of course, requires similarities in market structural defects and recognition of limitations in the analogy. In this report, we consider applying a Civil Aeronautics Board-type planning model to health services. The particular application concerns residents of rural

areas who have significantly less access to comprehensive health services than do persons living in more populated areas. The primary underlying cause is that physicians prefer to practice in urban areas. Additional complicating factors include difficulties in providing services on small scales, the time patients must spend in traveling to receive services, and lesser per capita incomes of rural residents. Consequently, health planners are searching for ways to provide better health service to rural areas at a reasonable cost. The CAB faced a similar problem in bringing airline services to areas other than large metropolitan centers. While the CAB is a comprehensive planning body with franchising and subsidy powers, unlike those currently available to health planning bodies, both industries share important structural similarities. These similarities include a publicly subsidized facility, resource indivisibilities, and a recognized need for regional market expansion. We discuss the results of airline planning undertaken by the CAB and suggest general principles that can effectively be transferred to health planning. (Journal Abstract)

8. Brooks, C. H. Associations among distance, patient satisfaction, and utilization of two types of inner-city clinics. Medical Care, 1973, 11, 373-383.

The association between distance traveled by a patient to an inner-city clinic and his utilization of its services is investigated. Clinics are divided into two types--large-bureaucratic and small-neighborhood--to determine the extent to which clinic size and administrative structure affect this relationship. "Source of patient referral" is related to distance and type of clinic. The relationship between frequency of attendance, which is an alternative to the distance-interval method of measuring utilization, and distance traveled to a clinic is also investigated. The study concludes by exploring the extent to which "patient satisfaction" is associated with frequency of attendance and with type of clinic. (Journal Abstract)

9. Downing, R. W. and Rickels, K. Patient personality and demographic factors as predictors of early response to psychotropic drug treatment. Comprehensive Psychiatry, 1970, 11, 568-575.

Quality of the patient's preliminary treatment response plays a critical role in determining both patient and physician set and influences the atmosphere in which medication effects take place. Preliminary treatment response may influence the patient's decision to complete his treatment program or to terminate it prematurely. In the present preliminary study the pool of potential predictors of drug treatment outcome included hostility, compliance, self-attitude, age, sex, occupation, education, anxiety, depression, severity of psychopathology, expectation about the use of drugs, and realization that problems were primarily emotional. Ss were 76 neurotic clinic outpatients. Results showed 3 independent factors affecting early improvement: predictors indicative of greater improvement in the (a) less adequate patient, (b) more adequate patient, and (c) patient whose presenting illness is less severe. Further work is in progress with larger samples attempting to explore questions raised by the present preliminary study. (Psychological Abstracts)

10. Galli, N. The influence of cultural heritage on the health status of Puerto Ricans. The Journal of School Health, 1975, 45, 10-16.

The problems of poor health among Puerto Ricans today are compounded by their cultural traditions. Many Puerto Ricans still rely on folk medicine

to cure their ills. One study by Suchman found that compared with persons of other ethnic groups in New York City, the Puerto Ricans are more suspicious of scientific medical care, tend to use general health services less, have more limited health horizons than any other ethnic group. Aside from the unsophisticated health practices stemming from a knowledge of Puerto Rican folk medicine, the cultural phenomena of spiritualism plays a significant role in retarding the health status of the Puerto Rican. Puerto Ricans who view illness as possession by evil spirits will consult a medium or curandero(a) for treatment instead of a physician. The hot and cold theory of disease has a profound influence on the Puerto Ricans' health status. In the attempt to achieve equilibrium of the four body humors, Puerto Ricans will often disregard a physician's advice which does not conform to this theory. Also, machismo, the concept of male dominance and superiority leads to sexual promiscuity, over population, venereal disease, family breakdown, early marriage, and a variety of health-related problems. (Journal Abstract).

11. Geertsen, R., Klauber, M. R., Rindflesh, M., Kane, R. L., and Gray, R. A reexmination of Suchman's views on social factors in health care utilization.

Suchman's model of health care utilization has been applied in a different social setting from that in which it was developed. The results of the application are contrasted with recomputations of Suchman's original data. These data raise some questions about the empirical reliability of the general model proposed by Suchman as a possible explanation of medical care behavior. The collective findings of the two studies open up several possibilities for alternative explanations of the varying relationships of the principal components of the original model; one such alternative model is presented. (Journal Abstract)

12. Greenlick, M. R., Freeborn, D. K., Gambill, G. L., and Pope, C. R. Medical Care, 1973, 11, 121-124.

The importance of the telephone in the American medical care system is only beginning to receive appropriate attention. Past studies indicate that a significant proportion of new diseases and a significant proportion of all medical care contacts take place by phone. A study of telephone use in a prepaid group practice system is presented. Data on telephone utilization are analyzed to determine the significance of telephone utilization of the population and to identify the patterns of telephone calls within total care seeking behavior. The purpose is to determine alternative modes of dealing with problems presented by phone or at least to assure that this important aspect of care is integrated into medical care. Telephone calls represented a significant proportion of the total medical care of the study population. About 50 percent of all phone calls to medical care personnel were concerning symptoms of disease and approximately 40 percent concerned laboratory results or prescriptions. Factors affecting the disposition of symptom phone calls were analyzed. It was hypothesized that the relative probability of a patient being told to come to the clinic after discussing a symptom would vary inversely with the certainty of the physician in his diagnosis and directly with the seriousness of the disease as perceived by the physician. The inferences from the data generally tended to support the hypotheses. These tendencies, however, were not strong enough to accurately predict when the physician would only discuss the symptom, give a prescription, or request a patient to visit. The concepts do not yet lend themselves to operational decision models for use by personnel trained to handle these

kinds of calls, because of tremendous individual variation among physicians that confounds attempts to predict the disposition of symptom phone calls using only patient, disease, and situational variables. (Journal Abstract)

13. Hoppe, S. K. and Heller, P. L. Alienation, familism, and the utilization of health services by Mexican Americans. Journal of Health and Social Behavior, 1975, 16, 304-314.

This study examines the influence of familism and occupational stability on alienation and health care utilization among lower-class Mexican Americans. It was found that familism and occupational stability were positively related to timing of prenatal care, but negatively related to consulting a physician when ill. Powerlessness was negatively related to timing of prenatal care and positively related to consulting when ill. The results suggest it is important to distinguish preventive and curative components of health care behavior in measures of utilization. In addition, the role of familism should be considered in the complex relationship between alienation and health care utilization. (Journal Abstract)

14. Hurtado, A. V., Greenlick, M. R., and Colombo, T. J. Determinants of medical care utilization: failure to keep appointments. Medical Care, 1973, 11, 189-198.

This study is an analysis of patient and physician characteristics that are related to failure of patients to keep an appointment in a prepaid, multispecialty group practice. There was a high relationship between the frequency of appointments and the frequency of appointment failures, leading to the conclusion that the probability of failures is relatively equal across appointments. High medical care utilizers, therefore, were most likely to have failures. Demographic and psychosocial patient characteristics, as well as physician characteristics, were of much less significance in determining patient failures to keep appointments. The medically indigent have a significantly higher rate of appointment failures which suggests that studies of appointment failures, when dealing with medically indigent populations, may have limited pertinence to other population groups. (Journal Abstract)

15. Jonas, S. Appointment breaking in a general medical clinic. Medical Care, 1971, 9, 82-88.

Appointment breaking was studied in a general adult medical clinic. Selected demographic characteristics and indices of past clinic-use patterns for a group of patients who broke a given appointment were compared with those for a group of patients who kept a given appointment. The data were collected during a series of clinic sessions held in January 1967, at the Gouverneur Health Services Program in New York City. The overall broken appointment rate in the clinics was 22 percent. There was a significantly higher proportion of Hispanics and Blacks as compared to Whites among the breakers than among the keepers. The breakers were also significantly younger than the keepers, most likely reflecting the White: Hispanic/Black age differential rather than being an independent variable. Among indices of past clinic-use patterns, the following differences between the two groups were statistically significant: Keepers had a higher average annual number of appointment visits, a higher percentage of kept appointments, and lower average annual numbers of broken appointments than did breakers. There were, however, no differences in the average annual number of nonappointment visits between breakers and keepers. The major conclusions of the study were that the breaker of a random appointment is more likely to be an habitual appointment-

breaker than is a keeper of a raondom appointment and is also more likely to use the clinic on a nonappointment basis. (Journal Abstract)

16. Kong-Kyun, R. Patient characteristics, hospital characteristics, and hospital use. Medical Care, 1969, 7, 295-312.

Previous studies explored two sets of relationships separately--one between patient characteristics and hospital use and the other between hospital characteristics and hospital use. This leaves the following questions unresolved. Is the revealed relationship between patient characteristics and hospital use a reflection of different medical philosophies practiced by individual hospitals whose distinct modes of practices attract patients with distinct characteristics?

Looking at the relations from the other side, is the revealed relationship between hospital characteristics and hospital use attributable to the fact that patients at hospitals with different characteristics have different sets of expectations and demands as shaped by their socioeconomic characteristics?

To seek answers to these questions, various interaction terms between the variables representing patient characteristics and those for hospital characteristics are formed, and their effects on hospital use are examined. The results provide some new insights into the consumption theory of hospital services.

17. Kymissis, P. Milieu specificity in medical practice: a study of sociopsychological variables concerning the husband and wife roles associated with hospitalization. International Mental Health Research Newsletter, 1975, 17, 7-8.

Studied differences in Greek perceptions of husband and wife roles relative to hospitalization. 30 hospitalized patients, 30 healthy control Ss matched by age and socioeconomic status, and Ss' spouses took the semi-projective Role Behavior Test. Results confirmed the 4 hypotheses: (a) Male patients, unlike healthy males, gave more status to themselves than to their spouses. (b) Male, unlike female, patients gave more love to themselves than to their spouses. (c) Female patients gave more status to spouses than did male patients. (d) Healthy males gave more status to spouses than did male patients. Greek male status needs are threatened by hospitalization, and the resultant role discontinuity can hinder treatment efforts unless men regain some status by being allowed choices during treatment. Hospitalized Greek women experience less role discontinuity since their ordinary social status is more subordinate. To foster whole patient treatment, cultural needs should be studied and accommodated by those responsible for health care. (Psychological Abstracts)

18. Ludwig, E. G. and Gibson, G. Self perception of sickness and the seeking of medical care. Journal of Health and Social Behavior, 1969, 10, 125-133.

It was hypothesized that among subjects who perceive themselves to be in poor health, those with fewer or less urgent symptoms, whose life situation makes it more difficult to seek care, and who lack faith in the medical care system would be most likely to fail to seek medical attention. The hypothesis was tested with a population of applicants for social security disability benefits. The hypotheses was only partially confirmed. Two life situational factors of income and welfare contact, and three measures of system orientation were found to be related to the seeking of medical care, but urgency and number of symptoms were not. Subjects with low income, recent welfare contact, and negative system orientations were most likely

to fail to seek medical attention. Moreover, negative system orientations proved to be associated with low income and welfare experience suggesting that negative orientations may be created by situational factors and serve as rationalizations for failure to seek care when situational factors make it difficult to do so. (Journal Abstract)

19. Pope, C. R., Yoxhioka, S. S., and Greenlick, M. R. Determinants of medical care utilization: the use of the telephone for reporting symptoms. Journal of Health and Social Behavior, 1971, 12, 155-162.

This preliminary report is based on a study in progress for more than two years that seeks to identify significant determinants of medical-care utilization within a particular medical care system--The Oregon Region of the Kaiser Foundation Health Plan. The particular focus is on telephone utilization for the reporting of symptoms. The data presented here relate social and demographic characteristics of Plan members to telephone utilization and is a limited test of the hypothesis that more cosmopolitan persons with a more scientific health orientation are more likely to utilize the telephone than less cosmopolitan persons with a less scientific health orientation. (Journal Abstract)

20. Press, I. Urban illness: physicians, curers, and dual use in Bogota. Journal of Health and Social Behavior, 1969, 10, 209-218.

Describes and analyzes the dual use of physicians and curers in Bogota.

Interviewed 44 outpatients at a major semicharity hospital outpatient clinic and 48 curer patients chosen at random at the office of a highly successful curandero in a major Latin American city. Interviews were directed but open ended. A number of other curers types were also visited and described.

Concluded that in Bogota, both medical and curer facilities are abundant and readily available, that dual use of both appears to be most common among the low acculturation, low socioeconomic group. Suggests that the phenomenon is a complex one and identifies at least 3 major patterns: (1) Competition--wherein both physician and curer are thought competent. Both may be consulted for a given problem. (2) Compartmentalization--wherein patients view physicians and curers as differing in competency or authority, each having control over certain manifestations being either unrecognized or uncontrolled by the other. (3) Exploitation--wherein patients attend physician or curer less for alleviation than for demonstration (to self or others) of social status, subgroup or cultural identity, degree of traditionality or modernity. (Representative Abstract)

21. Stephens, J. J. Socioeconomic status and related variables that influence the initiation of professional medical care among Montana families. Montana State Univ., Bozeman, Montana Agricultural Experiment Station, 1970, Report No. Bull-631, 52 p.

The purpose of this study was to determine for a sample of Montana families if a positive relationship existed between the family's socioeconomic status and its medical initiation behavior, and then, controlling for socioeconomic status, to determine if a relationship existed between initiation of professional medical care and a number of variables that perhaps affect the decision to visit the doctor or dentist. In the latter endeavor, a model suggested by McNerney and his colleagues was used to organize the analysis of several factors that may influence the decision to initiate medical care. A stratified sample of 574 families was surveyed.

Persons in the lower classes have poorer health than the more privileged. Yet, many persons with low incomes go to doctors and dentists, some as often as or more often than those with greater incomes. The hypothesis proposing a positive relationship between the ability to pay as measured by the possession of health insurance and the initiation of professional medical care is supported by the data, but only with some modifications. The general hypothesis seems to be tenable for the lower status group in the sample, but does not hold true for the higher status families. The family in the higher socioeconomic status group tends to initiate medical care at about the same rate whether it has health insurance or not. (Psychological Abstracts)

22. Stoeckle, J. D., Zola, I. K., and Davidson, G. E. On going to see the doctor, the contributions of the patient to the decision to seek medical aid. Journal of Chronic Diseases, 1963, 16, 975-989.

This paper is a highly selective review on some important features in the patients decision to seek medical aid. The influence of his environment, his objective clinical disorder and symptoms, as well as his perception, knowledge, beliefs and attitudes about having a particular disorder or symptom; his attitudes and expectations of the doctor and medical services and his definitions of health, sickness, and when medical care is necessary. It points out some of the areas in need for further research and the implication of this review for reorienting our thinking along the patients' perception of health and illness for planning more effective health care programs. (Author's Abstract)

23. Taylor, D. G., Aday, L. A., and Andersen, R. A social indicator of access to medical care. Journal of Health and Social Behavior, 1975, 16, 39-49.

This study introduces a social indicator of access to medical care--the symptoms-response ratio--that reflects the difference between the number of visits in response to symptoms that actually occur and the number that a panel of physicians indicate is appropriate for these same symptoms. Findings on the index for a national sample of the United States population affirm differentials in access that are generally thought to exist in terms of other access indicators (conventional use measures, insurance coverage, etc.). Nonwhites, rural farm people, the poor, and those who have no usual place to go for medical care were found to have less access to care than would be judged appropriate, based on the symptoms-response index. The index also suggests possible "over-utilization" among certain groups such as children and people who see specialists as their regular source of care. (Journal Abstract)

24. Weiss, J. E. and Greenlick, M. R. Determinants of medical care utilization: the effect of social class and distance on contacts with the medical care system. Medical Care, 1970, 8, 456-462.

This paper tests the notion that social class will measure differences in patterns of entry into the medical care process and that entry patterns will be affected by distances. The study was made using a 5 percent sample of the Kaiser Foundation Health Plan membership of the Portland, Oregon S.M.S.A. in 1967. The population was dichotomized into working class and middle class on the basis of occupation. The working class was made up of machine operators and unskilled employees and the balance of the population comprised the middle class. Distance was determined in miles from residence to the nearest Kaiser facility. The data indicate that social class differentiates patterns of entry into the medical care system, but that when total initial contacts for each social class are examined by distance

intervals, further differences emerge. The study, therefore, suggests that distance affects the medical care process differentially by social class and interacts with social class as an explanatory variable. (Journal Abstract)

25. Welch, S., Comer, J., and Steinman, M. Some social and attitudinal correlates of health care among Mexican Americans. Journal of Health and Social Behavior, 1973, 14, 205-213.

A sample of Mexican Americans was interviewed to ascertain their attitudes toward medical care and doctors and to determine what kinds of medical care they are receiving. Social characteristics of the respondents are examined to explain differences in "folk" medical beliefs. Beliefs are most strongly related to the size of the Mexican-American community the respondent lives in, but are not highly correlated with any characteristic. Finally, an attempt is made to explain variance in the utilization of medical services by both social and attitudinal variables. Utilization of medical services is found to be related more to class and age than either to attitudes toward modern medicine or to respondent's closeness to "Mexican culture." (Journal Abstract)

Compliance

1. Baekeland, F. and Lundwall, L. Dropping out of treatment: a critical review. Psychological Bulletin, 1975, 82, 738-783.

After a discussion of methodological issues, literature on dropping out of treatment is critically reviewed in 6 areas: hospital treatment of general psychiatric and tubercular patients, outpatient treatment of internal medical conditions, alcoholism, heroin addiction, general psychiatric outpatient psychotherapy, and double-blind drug studies. 15 factors were found to predict dropping out in 100%, 83-88%, and 60-75% of the relevant studies: (a) social isolation and/or unaffiliation, therapist attitudes and behavior, discrepancies between patient and therapist treatment expectations; (b) passive-aggressive behavior, family attitudes and behavior, motivation, behavioral and/or perceptual dependence, psychological mindedness and/or denial, symptom levels and symptom relief, socioeconomic status, sociopathic features, alcoholism and/or drug dependence; and (c) age, sex, and social stability. (Psychological Abstracts)

2. Biggs, J. T., Chang, S., Sherman, R., and Holland, H. Measurement of tricyclic antidepressant levels in an outpatient clinic. Journal of Nervous and Mental Disease, 1976, 162, 45-51.

Obtained data from 150 outpatients to determine if the routine measurement of plasma tricyclic antidepressant levels was practical in a large clinic population and if such levels could improve patient care. Plasma analysis revealed both the failure to ingest adequate amounts of medication as prescribed and also the abuse of medications. Although generalizations regarding individual variation in drug metabolism or generalizations concerning drug compliance do little to improve patient care, whenever such problems are met on an individual basis, many clinical management problems can be resolved. Five case examples are included to illustrate issues related to proper drug ingestion, drug metabolism rate, treatment failures despite adequate drug levels, side effects, and medication abuse. (Psychological Abstracts)

3. Brand, F. N. and Smith, R. T. Medical care and compliance among the elderly after hospitalization. International Journal of Aging and Human Development, 1975, 5, 331-346.

Follow up of 14 chronically ill patients 6 mo. after discharge from a general hospital revealed a high readmission rate (34%), a high utilization of hospital services, outpatient clinics, and family practitioners. The study of compliance with physician's recommendations showed that 42% of all patients interviewed did not comply with 1 or more recommendations. The reasons for noncompliance were related to the deficiencies of community health and social agencies, the patient's attitude or understanding of the instructions, the cost of drugs, and other factors. The lack of compliance was associated with marital status, education, income, and severity of disease. (Psychological Abstracts)

4. Davis, M. S. Variations in patients' compliance with doctors' advice: an empirical analysis of patterns of communication. American Journal of Public Health, 1968, 58, 274-288.

This paper deals with the extent to which patients do not comply with doctor's advice and with the factors that may be involved in explaining

these variations. It focuses on the ways in which dimensions of doctor-patient interaction relate to patient compliance.

The data reported in this study, collected by means of tape recordings of doctor-patient interviews, a self-administered questionnaire completed by physicians, and a content analysis of patients' medical records, were analyzed to determine the extent of deviant patient behavior within and outside the doctor-patient relationship.

Thirty-seven percent of the patient group disregarded what their doctors advised. A factor analysis suggested some patterns of communication which help explain noncompliance. While interaction in the primary doctor visit was not associated with later compliance, the data suggest that revisits between an authoritative patient and a physician who passively accepts such patient participation may promote patient noncompliance. Effective communication is impeded when doctors and patients evidence tension in their relationship. Unless this tension is released, noncompliance may result, regardless of the doctor's efforts to achieve solidarity. And when doctors seek information from patients without giving them any feedback, the patient is unlikely to follow the doctor's orders once they are formulated. (Representative Abstract)

5. Gillum, R. F. and Barsky, A. J. Diagnosis and management of patient noncompliance. Journal of the American Medical Association, 1974, 228, 1563-1567.

Considers that patient noncompliance with medical regimens is one of the major unsolved therapeutic problems confronting the medical profession today. Physicians have great difficulty identifying and dealing with noncompliers. A critical review of the literature is presented which indicates that the factors most consistently related to noncompliance are (a) psychological factors, (b) environmental and social factors, (c) characteristics of the therapeutic regimen, and (d) properties of the physician-patient interaction. Based on this information, a strategy for the improved diagnosis and management of noncompliance is feasible. (Psychological Abstracts)

6. Gorois, L., Markowitz, M., and Lilienfeld, A. M. The inaccuracy in using interviews to estimate patient reliability in taking medications at home. Medical Care, 1969, 7, 49-54.

Compliance with physicians' instructions for continuous penicillin prophylaxis against rheumatic fever recurrences was estimated from results of periodic urine tests for penicillin and compared with compliance based on reports from the patients or their mothers. In the group of patients studied, 69 to 73 percent would be considered compliers from the histories given by the patients or their mothers, but in actuality only 33 to 42 percent were indeed compliers, as shown by urine tests. The data demonstrate that estimates of compliance based on reports by patients or their relatives are grossly inaccurate. The error introduced by the use of such indirect measures of compliance has important implications for clinical drug trials and for medical care research. (Journal Abstract)

7. Kaplan de-Nour, A. and Czaczkes, J. W. Personality factors in chronic hemodialysis patients causing noncompliance with medical regimen. Psychosomatic Medicine, 1972, 34, 333-344.

Observed 43 patients on chronic hemodialysis in a prospective study on the effects of a number of personality factors on noncompliance with a medical regimen (diet). It was found that low frustration tolerance and gains (primary and secondary) from the sick role were the most frequent

causes for noncompliance, and these differentiated significantly between compliers and noncompliers. Acting out was frequent in both groups, although more sever in the noncompliers. Other factors, e.g., denial of sick role and suicidal behavior, were also found. (Psychological Abstracts)

8. Kupst, M. J., Doesser, K., Schulman, J. L., and Paul, M. H. Improving physician-parent communication: some lessons learned from parents concerned about their child's congenital heart defect. Clinical Pediatrics, 1976, 15, 27-30.

A project designed to improve understanding between physicians and parents of patients was undertaken at the Children's Memorial Hospital of Chicago. Eighty-eight randomly selected parents bringing their children to the cardiac outpatient department were interviewed before their child was examined, and a questionnaire was administered before and after the medical examination and by mail one month later. The questions were designed to determine the amount of knowledge present before the interview, the parents' recall of the medical information, and its retention one month later. They were also asked about their reaction and comments about the visit. Parents tend to focus their attention on areas where they are directly responsible, such as instructions about medication and physical activity. Hence, the physician should give clear, detailed instructions, written as well as oral, about the actions and precautions needed for proper care of their child. Since parents feel a need for much information about prognosis and possible treatments, the physician should give as clear an explanation as possible at every visit. The physician should continually mention that regarding future procedures and treatment are subject to change also. Most parents feel that the academic, clinical information is not very important to them. Instead, most prefer a descriptive summary and diagram. They may not remember such information well, yet want to be able to look it up when they need it. Physicians should encourage questions at each visit. In addition, we found that sending a follow-up questionnaire a month after the visit was quite helpful. Parents often think of questions after they leave the clinic. These later questions may be answered by the cardiologist in a letter. Most parents were pleased that the staff was interested in them and cared about what they understood. This is perhaps the most important lesson learned from our survey. More than anything else, a feeling of caring helps enormously in maintaining communication in the physician-patient-parent relationship when a child has congenital heart disease or presumably some other chronic condition. (Representative Abstract)

9. Lorber, J. Good patients and problem patients: conformity and deviance in a general hospital. Journal of Health and Social Behavior, 1975, 16, 213-225.

Investigated the attitudes and behavior of 103 surgical patients and the reactions of doctors and nurses to that behavior. Previous research had suggested that medical personnel encourage trust, cooperation, uncomplainingness and undemandingness in patients, but that not all patients subscribe to these norms to the same degree. Results of the present study show that Ss did differ in the extent of their acceptance of good-patient norms and, as predicted, that those who did not completely accept them were less submissive to hospital routines than those who did. The doctors and nurses tended to term Ss who interrupted well-established routines and made extra work for them "problem patients," but how such Ss were treated depended on the severity of their illness. It is noted that possible consequences of being labeled a problem patient are premature discharge, neglect, and referral to a psychiatrist. (Psychological Abstracts)

10. Marston, M. V. Compliance with medical regimens: a review of the literature. Nursing Research, 1970, 19, 312-323.

To a great extent, the accuracy of any estimate of compliance is dependent upon the measurement tools used. More confidence can be placed in the results of objective measures such as excretion tests and pill counts than in the results of more subjective measures such as patient report or estimates made by others. When it is necessary to rely primarily on patient report, compliance estimates are probably inflated. In the literature which was reviewed, it was found that when demographic variables were examined separately, little or no association was found between compliance behavior and sex, age, race, marital status, socioeconomic status, or education. It is unclear whether actual severity of illness is related to compliance; although severity, as perceived by the patient, probably results in increased compliance. Increased numbers of different recommendations may be associated with more serious illnesses, and noncompliance increases with the complexity of the regimen. Knowledge alone concerning illness and its treatment has not provided sufficient motivation for parents to know their regimens. The recent use of various personality tests to predict compliance has also been disappointing. We have much to learn concerning the appropriateness of using various psychological tests on physically ill patients in their middle and later years. Many personality tests have been developed and used primarily with college students and young adults, who happened to be accessible and willing subjects. Most of these measures have not been used with subjects in their middle and older years. The effects of increased age and the crisis nature of many types of illness make it necessary for us to rethink our assumptions concerning the enduring quality of personality characteristics, as measured by these tests. Although the types of interactions which occur between patients and their physicians have been found to be predictive of compliance behavior, the literature does not contain studies of the role of the nurse in promoting compliance. Nurses spend more itme with patients than do physicians, and thus potentially have more opportunity to influence their health behavior. More systematic investigations of effective nurse-patient interactions are needed. Research in the use of fear communications has indicated that fear communications, when accompanied by practical instructions for reducing or eliminating the threat, are effective in motivating people to undertake diagnostic and preventive health measures. However, investigations of the judicious use of fear communications to promote compliance with medical regimens may be in order. The literature on body image indicates that patients more readily incorporate gradually occurring changes in their bodies into their notions about themselves than is the case with sudden illness or trauma. From this literature review, no clear picture emerges concerning the determinants of compliance. Because of the lack of consistency of research findings; in the future, it would probably be more fruitful to investigate several factors simultaneously. Some of the more promising predictors of compliance have been the types of interactions which occur between patients and physicians and the use of fear communications. It seems likely that compliance with medical regimens is determined by some type of interaction effect involving demographic, illness, and social-psychological variables. A better understanding of the roles of these variables is needed in order to know how best to assist patients in caring for their own health. (Representative Abstract)

11. Mattar, M. E., Markello, J., and Yaffe, S. J. Pharmaceutic factors affecting pediatric compliance. Pediatrics, 1975, 55, 101-108.

Evaluation of treatment given at home was studied in children with otitis media who were seen in an outpatient clinic. Full compliance was

present in only 5% of the initial 100 patients (Study A). Practical factors limiting their compliance included inadequate dispensing of medication at drug stores, 15%; incorrect therapy schedule, 36%; early termination, 37%; spilled medicine, 7%; therapy shared, 5%. Because of these findings, a plan was implemented (Study B) in which hospital pharmacy personnel gave patient families verbal and written instructions for administering medications that were dispensed, together with a calibrated measuring device and a calendar to record doses taken. Full compliance was raised to 51% in this pilot group (of 33 patients) as compared with 8.5% in 200 concurrent controls who went to neighborhood drug stores.

The importance of detailed therapy instructions is stressed. The potential role of the pharmacist in improving compliance is demonstrated. (Journal Abstract)

12. Raimbault, G., Cachin, O., Limal, J. M., Eliacheff, C., and Rappaport, R. Aspects of communication between patients and doctors: an analysis of the discourse in medical interviews. Pediatrics, 1975, 55, 401-405.

The transcripts of tape-recorded interviews of pediatric endocrinologists and patients with Turner's syndrome and their parents were reviewed in consultation with child psychoanalysts in order to evaluate certain aspects of communication between patients and doctors. The transcripts showed that the doctors often talked at cross purposes with the parents and their patients, evading emotional issues in favor of quasiscientific explanations which the patients and parents did not understand. Parts of the discourse, at times unconscious, have been shown to be of great importance as means of communication. Reviewing the transcripts of the doctor-patients discourse is an excellent way of improving one's therapeutic communication with the patient. The same material can be used for teaching purposes. (Journal Abstract)

13. Starkman, M. N. and Youngs, D. D. Psychiatric consultation with patients who refuse medical care. International Journal of Psychiatry in Medicine, 1974, 5, 115-123.

Ethical and pragmatic issues related to patient refusal of medical care are considered, and a comprehensive approach to psychiatric evaluation and management is presented. Legal interventions which may be utilized are described. The medical-legal committee and the interdisciplinary case conference are suggested as avenues for dialogue, problem solving, and education. (Psychological Abstract)

14. Stimson, G. V. Obeying doctor's orders: a view from the other side. Social Science and Medicine, 1974, 8, 97-104.

Points out that implicit images of human behavior influence most research endeavors. An analysis of 19 drug studies showed that most of them, in discussing patients' "compliance" with doctors' instructions, used an ideal image of the patient as a passive, obedient, and unquestioning recipient of medical instructions. Divergence from this ideal--"defaulting"--is seen as irrational in the light of medical rationality. The blame for "default" is seen as lying with the patient. The research problem from the medical view is to find out what there is about the patient that makes him a defaulter. An alternative approach from the perspective of the patient is suggested. The focus is on the social context in which the illnesses are lived and treatments used. A more active view of patients is entailed

in which patients have expectations of the doctor, evaluate the doctor's actions, and are able to make their own treatment decisions. Rather than "defaulting" being found in certain types of individuals, almost anyone can be a "defaulter" at some time or another. (Psychological Abstract)